

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2010
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 06	STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from November 18, 2010 through November 19, 2010. A random sampling of three clients was selected from a population of six males with various cognitive and intellectual disabilities. This survey was initiated utilizing the fundamental process.</p> <p>The findings of the survey were based on observations and interviews with clients and staff in the home and at two day programs, as well as a review of client and administrative records, including incident/investigation reports.</p>	W 000		
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the qualified mental retardation professional (QMRP), for four of six clients residing in the facility. (Clients #2, #3, #5, and #6)</p> <p>The findings include:</p> <p>1. The facility's QMRP failed to ensure the day program was made aware of the change in Client #3's prescribed diet, as evidenced below:</p> <p>On November 18, 2010, at 4:12 p.m., observations of the evening snack revealed Client</p>	W 159	<p style="text-align: center;"><i>Received</i> DEC 17 2010</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marta Jhanay</i>	TITLE <i>Vice President</i>	(X6) DATE <i>12/6/10</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Health Regulation Administration

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I 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from November 18, 2010 through November 19, 2010. A random sampling of three residents was selected from a population of six males with various cognitive and intellectual disabilities. This survey was initiated utilizing the fundamental process.</p> <p>The findings of the survey were based on observations and interviews with clients and staff in the home and at two day programs, as well as a review of client and administrative records, including incident/investigation reports.</p>	I 000		
I 047	<p>3502.5 MEAL SERVICE / DINING AREAS</p> <p>Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the Group home for mentally retarded persons (GHMRP's) failed to ensure that residents received their meals as outlined in their dietary plan, for one of three residents included in the sample. (Resident #3)</p> <p>The finding includes:</p> <p>The Cross refer to (I)0180. The GHMRP's qualified mental retardation professional (QMRP) failed to ensure the day program was made aware of the change in Resident #3's prescribed diet.</p>	I 047	<div style="border: 1px solid black; padding: 5px;"> <p>I 047 A case conference will be held with client #3's day program to discuss dietary needs.</p> <p>On quarterly basis, the residential facility will hold quarterly meetings with the day program to discuss dietary needs and other related welfare subjects.</p> </div>	<p style="text-align: right;">12/19/10 12/19/10</p>

Health Regulation Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marta Thomas</i>	TITLE <i>Vice President</i>	(X6) DATE <i>12/15/10</i>
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I 180	Continued From page 1	I 180		
I 180	<p>3508.1 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure adequate administrative support had been provided to efficiently meet the needs of the residents as required by their habilitation plans, for four of six Residents residing in the GHMRP. (Residents #2, #3, #5, and #6)</p> <p>The findings include:</p> <p>1. The GHMRP's QMRP failed to ensure the day program was made aware of the change in Resident #3's prescribed diet, as evidenced below:</p> <p>On November 18, 2010, at 4:12 p.m., observations of the evening snack revealed Resident #3 received a double portion of fruit (banana/apples). At approximately 6:10 p.m., Resident #3 was observed to receive double portions of roast beef, boiled potatoes, broccoli, oatmeal cookies, and beverages during dinner time. On November 19, 2010, at approximately 12:15 p.m., observations conducted at the day program revealed Resident #3 received regular portions of meatloaf, kale, mashed potatoes, and wheat bread during lunch time.</p> <p>Interview with the day program's case manager (CM) and registered nurse (RN) on November 19, 2010, at approximately 12:25 p.m., revealed that they both were unaware that Resident #3's</p>	I 180		

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I 180	<p>Continued From page 2</p> <p>prescribed diet had change. The RN indicated that Resident #3's current physician's orders dated November 2010 did not include double portions at every meal and every snack.</p> <p>Interview with the GHMRP's RN on November 19, 2010 at approximately 3:47 p.m., revealed that Resident #3's diet was changed to double portions in July 2010. Further interview with the RN revealed that the current physician's orders sent to the day program did not reflect the change in Resident #3's diet.</p> <p>Review of Resident #3's medical records on November 18, 2010, beginning at 2:54 p.m., revealed current physician's orders (PO's) dated November 2010. According to the PO's, Resident #3's was prescribed a 2-3 gram sodium, high fiber, double portion diet at every meal and every snack, and ensure plus one can two times a day. Further review of the medical records revealed a telephone written order to "please add double portion to Resident #3 diet recommended by the nutritionist and approved by the primary care physician (PCP) on July 16, 2010." This was confirmed through review of the third nutritional quarterly dated July 2010 on the same day at approximately 4:00 p.m.</p>	I 180	<div style="border: 1px solid black; padding: 5px;"> <p>I 180 A case conference will be held with client #3's day program to discuss dietary needs.</p> <p>On quarterly basis, the residential facility will hold quarterly meetings with the day program to discuss dietary needs and other related welfare subjects.</p> </div>	
I 401	<p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.</p> <p>This Statute is not met as evidenced by:</p>	I 401		

~~01/15/11~~
12/19/10

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I 401	<p>Continued From page 3</p> <p>Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure professional services and treatment services designed to prevent deterioration or further loss of function for two of the three in the sample. (Residents #1 and #2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The GHMRP failed to ensure Resident #1 received medication recommended by the otolaryngologist to soften ear wax, as evidenced below: <p>Interview with the registered nurse (R.N.) on November 19, 2010 at 11:00 a.m. revealed that Resident #1 had frequent Ear, Nose, and Throat (ENT) clinic appointments due to incomplete removal of ear wax during the visits. The nurse also indicated the otolaryngologist recommended that the resident be prescribed ear drops prior to his ENT appointments, to soften the wax.</p> <p>Record review on November 19, 2010, at 11:17 a.m. revealed on April 22, 2010, the otolaryngologist diagnosed Resident #1 with a bilateral ear wax impaction. The specialist noted that the wax in both ears looked very dry and recommended to use ear drops as instructed for one week prior to the return appointment on June 17, 2010.</p> <p>A physician's order prescribed that Resident #1 be administered A and B otic ear solution, in both ears three times a day for 7 days prior to visit for cerumen removal in May 2010. According to the medication administration record (MAR), the resident received the drops from May 9, 2010, to May 14, 2010, however did not return to the ENT until June 17, 2010.</p>	I 401		

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I 401	<p>Continued From page 4</p> <p>On November 19, 2010 at 12:28 p.m. the RN confirmed that Resident #1 did not receive ear drops in June 2010 prior to the scheduled ENT appointment (June 17, 2010). The RN indicated that due to the conflicting dates on the consultation report, it was unclear whether the appointment was scheduled for May or June, 2010.</p> <p>On June 17, 2010, the otolaryngologist noted Resident #2's ears were still impacted and that the wax was partially removed. The otolaryngologist again recommended A and B otic solution to both ears one week prior to return in two months. At the time of the survey, the GHMRP failed to provide evidence that Resident #2 received his ear drops as recommended.</p> <p>2. The GHMRP failed to ensure that Resident #2 received Seroquel as prescribed, as evidenced below:</p> <p>During the medication administration on November 18, 2010 at 7:12 p.m., Resident #2 received Seroquel UD 300 mg. Interview with the registered nurse (RN) during the medication administration revealed that the medication was prescribed for behavior.</p> <p>Further discussion with the RN on November 19, 2010 at 12.17 p.m. revealed the Resident #2 should receive Seroquel at 7:00 a.m. at the group home and also receive it at the day program at 1:00 p.m.</p> <p>On November 19, 2010, at 12:25 p.m., verification of the medications administered confirmed that Resident #2 was prescribed Seroquel 300 mg in the evening, and Seroquel</p>	I 401	<div style="border: 1px solid black; padding: 5px;"> <p>I 401, 1 & 2</p> <p>The facility's Registered Nurse (RN) will in-service the Trained Medication Employees (TMEs) and Licensed Practical Nurses (LPNs) on adhering to physician's orders.</p> <p>A case conference will be held with the day program to discuss client #2's medication regimen and the need to adhere to physician's orders.</p> <p>On a monthly basis, the facility's RN shall review the day program's and facility's MARs to ensure that client #2's medications are dispensed as prescribed and the MARs reflect the correct dispensation of meds.</p> </div>	<p>01/25/11 12/19/10</p>

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I 401	<p>Continued From page 5</p> <p>200 mg UD every day at 1:00 p.m. According to the September 2010 medication administration records (MARs), the resident was not administered Seroquel 200 UD at 1:00 p.m. on September 2, 2010. Review of the group home and day program MARs revealed "Seroquel " medication not given."</p> <p>Continued discussion with the RN on November 19, 2010, at 3:40 p.m. revealed she was unable to determine why the resident did not receive Seroquel UD 200 mg on September 2, 2010 at 1:00 p.m.</p> <p>At the time of the survey, there was no evidence the GHMRP ensured that Resident # 2 had received each medication as prescribed.</p>	I 401		